Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – Flu Season is upon us! CMS encourages providers to begin taking advantage of each office visit to encourage your patients with Medicare to get a seasonal flu shot; it's their best defense against combating seasonal flu this season. (*Medicare beneficiaries may receive the seasonal influenza vaccine without incurring any out-of-pocket costs. No deductible or copayment/coinsurance applies.*) For more information about Medicare's coverage of the seasonal influenza vaccine and its administration as well as related educational resources for health care professionals, please go to ***http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*** on the CMS website.

MLN Matters® Number: MM6742 **Related Change Request (CR) #: 6742**

Related CR Release Date: November 27, 2009 **Effective Date: January 1, 2010**

Related CR Transmittal #: R1862CP **Implementation Date: January 4, 2010**

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update

Provider Types Affected

This article is for physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed

CR 6742, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs). The CR is effective January 1, 2010.. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-

of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month. A national code maintenance committee maintains the CARCs. That Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early March, July, and November. Both code lists are posted at ***http://www.wpc-edi.com/Codes*** on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 6742.

CMS has also developed a tool to help you search for a specific category of code and that tool is available at ***http://www.cmsremarkcodes.info*** on the Internet. Note that this website does not replace the Washington Publishing Company (WPC) site. That site is ***http://www.wpc-edi.com/Codes*** and, should there be any discrepancies in what is posted at the CMS site and the WPC site, consider the WPC site to be correct.

Additional Information

To see the official instruction (CR6742) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to ***http://www.cms.hhs.gov/Transmittals/downloads/R1862CP.pdf*** on the CMS website. If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC at their toll-free number which may be found at ***http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*** on the CMS website.

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
232	Institutional transfer amount. Note: Applies to Institutional claims only and explains the DRG amount differences when patients care crosses multiple institutions.	11/1/2009
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	11/1/2009

Modified Codes - CARC

Code	Current Modified Narrative	Effective Date Per WPC Posting
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

Code	Current Modified Narrative	Effective Date Per WPC Posting
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance AdviceRemark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
107	Related or qualifying claim/service was not identified on the claim. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
152	Payer deems the information submitted does not support this length of service.	7/1/2010
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

Code	Current Modified Narrative	Effective Date Per WPC Posting
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an “Alert”.)	7/1/2010
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an “Alert”.)	7/1/2010

Code	Current Modified Narrative	Effective Date Per WPC Posting
148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided ((may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 07/01/2010: Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 REF Segment: Healthcare Policy Identification, if present.	7/1/2010

Deactivated Codes - CARC

Code	Current Narrative	Effective Date
87	Transfer Amount	1/1/2012
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	1/1/2012

New Codes - RARC:

Code	Current Narrative	Medicare Initiated
N521	Mismatch between the submitted provider information and the provider information stored in our system.	NO
N522	Duplicate of a claim processed as a crossover claim.	NO

Modified Codes – RARC:

Code	Modified Narrative	Medicare Initiated
M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	NO
M118	Letter to follow containing further information.	NO
N59	Please refer to your provider manual for additional program and provider information.	NO
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	NO
N202	Additional information/explanation will be sent separately.	NO

Deactivated Codes – RARC

None